



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN JACINTO METHODIST
4401 GARTH RD
BAYTOWN TX 77521-2122

Respondent Name

CHURCH MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 17

MFDR Tracking Number

M4-11-0741-01

MFDR Date Received

November 4, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "claim considerably underpaid. did not allow correct amount."

Amount in Dispute: \$2,642.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent audited this bill in accordance with Requestor's contract with Integrated Health Plan. This was the only reduction taken for the primary procedure. No additional reimbursement is owed."

Response Submitted by: Downs Stanford, PC, 2001 Bryan Street, Suite 4000, Dallas, Texas 75201

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 12, 2010	Outpatient Hospital Services	\$2,642.56	\$2,592.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers of any person that is given access to the informal or voluntary network's fee arrangement with that health care provider.
5. Texas Labor Code §413.011(d-3) specifies the contract information that shall be provided on Division request.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 193 – Original payment decision maintained
- 97 – Charge Included in another Charge or Service
- ORC – See Additional Information
- TC – Technical Component
- 59 – Distinct Procedural Service
- B15 – Procedure/Service is not paid separately
- RT – Right Side
- R89 – CCI; Misuse of Column 2 code with Column 1 code
- W3 – Additional payment on appeal/reconsideration
- 45 – Contract/Legislated Fee Arrangement Exceeded
- RN – Not paid under OPPS: services included in APC rate

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent's position statement contends that "Respondent audited this bill in accordance with Requestor's contract with Integrated Health Plan." The insurance carrier reduced or denied disputed services with reason code 45 – "Contract/Legislated Fee Arrangement Exceeded." Review of the submitted information found insufficient evidence to support that the services in dispute are subject to a contracted fee arrangement. Pursuant to 28 Texas Administrative Code §133.307(e)(1), which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available" and Texas Labor Code §413.011(d-3), which states, in pertinent part, that "An insurance carrier shall provide copies of each contract described by Subsection (d-1) to the division on the request of the division. . . . For medical fee disputes that arise regarding non-network and out-of-network care, the division may request that copies of each contract under which fees are being paid be submitted to the division for review"; on January 11, 2011, the Division requested the respondent to provide a copy of the referenced network contract and documentation to support provider notification as required under 28 Texas Administrative Code §133.4. The respondent did not provide copies of the requested information. The above denial/reduction reason is not supported. Pursuant to §133.307(e)(1) and Texas Labor Code §413.011(d-3), which states, in pertinent part, that "the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract: (1) is not provided in a timely manner to the division on the division's request," the disputed services will be reviewed for payment based on the available information in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

- Procedure code 85018 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is \$3.39. 125% of this amount is \$4.24. The recommended payment is \$4.24.
 - Procedure code 29880 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of \$2,016.77. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,210.06. This amount multiplied by the annual wage index for this facility of 0.9934 yields an adjusted labor-related amount of \$1,202.07. The non-labor related portion is 40% of the APC rate or \$806.71. The sum of the labor and non-labor related amounts is \$2,008.78. The cost of this service does not exceed the annual fixed-dollar threshold of \$2,175. The outlier payment amount is \$0. The total APC payment for this service, including outliers and any multiple procedure discount, is \$2,008.78. This amount multiplied by 200% yields a MAR of \$4,017.56.
 - Per Medicare policy, procedure code 29877 is unbundled. This service is a component procedure of procedure code 29880 performed on the same date of service. Payment for this service is included in the payment for the primary procedure. A modifier is not allowed. Separate payment cannot be recommended.
 - Procedure code J1100 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J1885 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
 - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
4. The total recommended payment for the services in dispute is \$4,021.80. This amount less the amount previously paid by the insurance carrier of \$1,429.65 leaves an amount due to the requestor of \$2,592.15.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$2,592.15.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$2,592.15, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> September 14, 2012 Date
---	---	---

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.